such advertisements to the FDA before they are aired.

In passing the FDAAA, Congress also reauthorizes the Best Pharmaceuticals for Children Act (BPCA) and the Pediatric Research Equity Act (PREA), both of which were set to expire on September 30. Since its original passage, the BPCA has done more than any other initiative to generate vital information about the use of medicines in pediatric populations and to promote research on the use of pharmaceutical products in children. The BPCA and PREA were designed to work in tandem to promote and support pediatric research. Therefore, it is critical that these two programs remain linked, as they are in the FDAAA.

Since its original enactment in 1992, PDUFA has been a resounding success. It has enabled the timely review of new medicines while at the same time preserving FDA's strict and objective review process. As a result, more than 1,000 new medicines have been made available to patients over the past 15 years. These medicines have helped millions of people lead healthier, more productive lives, and contributed to a longer life expectancy than ever before. By reauthorizing PDUFA and passing the drug safety enhancements contained in the FDAAA, Congress has helped to ensure FDA's continued role as the authority on drug safety and drug regulation.

COMMENDING HERNDON INGE, OF MOBILE, ALABAMA, FOR HIS SERVICE DURING WORLD WAR II

HON. JO BONNER

OF ALABAMA

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 27, 2007

Mr. BONNER. Madam Speaker, it is my pleasure to rise today to recognize Judge Herndon Inge of Mobile, Alabama, for his courageous service during World War II. His heroic story, along with other Mobilians, is told in the Ken Burns' documentary series ''The War.''

Judge Inge attended the University of Alabama and then the Army's officer candidate school. He was commissioned January 7, 1944, and became a 2nd lieutenant in company D, 301st Regiment, 94th Infantry Division, in a heavy weapons unit.

Arriving in France in September of 1944, he and his division contained 60,000 German troops along the French coast at St. Lazaire and Lorient. Following the sinking of the USS *Leopoldville* when hundreds of American soldiers were killed, Lt. Inge was sent into the Battle of the Bulge. He was captured by German troops on January 21, 1945.

He was held at numerous POW camps, and he finally ended up in Oflag XIIIB near Hammelburg. He was liberated April 21, 1945. After the war, 1st Lt. Inge returned to Mobile. He attended law school and began his law practice in 1948. He was appointed Juvenile Court Judge and then appointed Circuit Judge of the Domestic Relations Division by then Alabama Governor Jim Folsom. At the time, he was the only judge in Mobile County to serve in both capacities at the same time.

Madam Speaker, the recognition of Judge Herndon Inge in ''The War'' documentary is an appropriate time for us to pause and thank him—and all of the soldiers who fought in World War II. They personify the very best America has to offer. I urge my colleagues to take a moment to pay tribute to Judge Inge and his selfless devotion to our country and the freedom we enjoy.

STRATEGIES TO ADDRESS ANTIMICROBIAL RESISTANCE (STAAR) ACT

HON. JIM MATHESON

OF UTAH

IN THE HOUSE OF REPRESENTATIVES

Thursday, September 27, 2007

Mr. MATHESON. Madam Speaker, I rise to introduce the ''Strategies to Address Antimicrobial Resistance (STAAR) Act,'' which I believe has the potential to save many thousands of lives by strengthening the United States' response to infectious pathogens that are becoming increasingly resistant to existing antibiotics. I am proud to introduce this legislation with my colleague, Rep. MIKE FERGUSON, as a concrete step towards addressing antibiotic resistance.

Media reports about the threat of resistant infections now occur on almost a daily basis. Earlier this year, media attention regarding extensively-drug resistant tuberculosis (XDR–TB) made this topic common conversation in our homes and offices. Suddenly we were forced to think about how quickly an infection can spread, especially in the age of international air travel, and the disastrous result if the cause was a strain of bacteria that failed to respond to our current antibiotics.

Another resistant infection drastically on the rise is community-acquired methicillin-resistant Staphylococcus aureus (CA–MRSA). Historically, this infection was acquired during a hospital stay, but now is affecting young, healthy people and spreading in our communities. We've heard stories of high school, college and professional athletes losing their lives or careers as a result of these infections. Sadly, this infection has become far too common, difficult to treat and has few options to fight it. It can leave individuals disfigured, if they survive. In my own state of Utah, the number of children with MRSA infections at the Primary Children's Medical Center in Salt Lake City has increased by almost 20 fold since 1989.

There are still more infections to worry about. We have numerous reports of our soldiers coming home from Iraq with Acinetobactor—a resistant infection that is especially difficult to treat and the only option is a very toxic antibiotic.

Other examples of concern include vancomycin-resistant Staphylococcus aureus (VRSA), an alarming development because vancomycin is the drug of last resort for treating several serious infections, and Escherichia coli (E. coli), which has caused outbreaks due to contamination of spinach, peanut butter, and other foods we regularly consume.

We have taken antibiotic development for granted. Few of us remember medicine before the discovery of antibiotics. Antibiotics have allowed many medical advances, including routine invasive surgeries, organ transplants, and other procedures that otherwise would be impossible due to resulting infections. But we are falling behind in our ability to protect ourselves against infections, and we have a lot of catching up to do.

In addition, there are problems of significant and inappropriate use of antibiotics; a lack of adequate research to address the many facets of resistance, including basic, clinical, interventional, and epidemiologic research as well as research to support the development of new diagnostics, biologics, devices and, of course, antibiotics; a fractured and underfunded resistance surveillance system; and insufficient coordination of the federal response, which is critically needed as the solutions to addressing antibiotic resistance involve multiple agencies and departments.

I am not the first person in the United States Congress to take on this issue. I feel certain, however, that the STAAR Act is the most comprehensive legislation introduced to date to address this serious and life-threatening patient safety and public health problem. There is no doubt that we must act now to begin to reverse the alarming trend, and infectious disease experts tell me that the multi-pronged approach contained in the STAAR Act provides our best chance to address the multiple problems that face us.

I commend my many colleagues who have demonstrated leadership on this issue over the years, especially Chairman DINGELL. He recognized this issue nearly 15 years ago and asked the Congressional Office of Technology Assessment (OTA) to examine the problem of antimicrobial resistance. In 1995, OTA reported to Congress that ''The impacts of antibiotic-resistant bacteria can be reduced by preserving the effectiveness of current antibiotics through infection control, vaccination and prudent use of antibiotics, and by developing new antibiotics specifically to treat infections caused by antibiotic resistant bacteria.''

Also, I would like to recognize the leadership of my colleague from Michigan, Mr. STUPAK. In the 106th Congress, he and our former colleague, Mr. BURR, introduced the ''Public Health Threats and Emergencies Act.'' Parts of this bill became law and provide the basis of the legislation I introduce today. Specifically, that bill, which is expressed in Section 319E, ''Combating Antimicrobial Resistance'' of the Public Health Service Act, directed the Secretary to establish an Antimicrobial Resistance Task Force to coordinate Federal programs relating to antimicrobial resistance. Also, the bill required research and development of new antimicrobial drugs and diagnostics; educational programs for medical and health personnel in the use of antibiotics; and grants to establish demonstration programs promoting the judicious use of antimicrobial drugs and the detection and control of the spread of antimicrobial-resistant pathogens. Authorization for these programs expired September 30, 2006. The STAAR Act reauthorizes these programs and builds on the Federal efforts that have been highlighted in the Public Health Service Action Plan to Combat Antimicrobial Resistance, published in 2001 by the Task Force.

The Action Plan identified thirteen key elements (out of 84 elements) as top priority action items that are critically necessary to address the growing resistance crisis. Only months after the release of the Action Plan, our former colleague Mr. BROWN and many of my colleagues on the Energy and Commerce Committee, including Chairmen DINGELL and PALLONE, and Mr. WAXMAN, Mr. TOWNS, Mr. GREEN, and Ms. DEGETTE, introduced the ''Antibiotic Resistance Prevention Act of 2001.''